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ABSTRACT

The development of mental health law has been rapid. Courts have recognized new rights and have taken away others. For institutionalized individuals, the exact parameters of the right to treatment and community placement and to refuse medication have begun to be clarified. Yet lack of resources as well as prejudice continue to prevent people with mental illnesses from being truly integrated into our society. In short, the issue of the rights and services to which people are entitled is likely to continue as a major battleground in the years ahead. Yet, as the history of the development of mental health law shows, courts have the potential to become significant players in the effort to develop community-care systems which provide decent conditions for people with mental illness. But it remains for expatients, consumers, family members, health care professionals, lawyers and other advocates to work together to fulfill that potential. One of the greatest challenges is to identify and implement strategies that will expand the availability of effective and quality community services and decent and low-cost housing. Failure to do so may result in either a return to the days of large custodial institutions or the reality of people left to live and die on the streets of our nation's cities. (ABL)

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CURRENT ISSUES IN MENTAL HEALTH LAW

by Arlene S. Kanter

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Foreword

In September, 1988, the Hogg Foundation held the sixth in its series of Robert Sutherland Seminars, this one focusing on community care for the chronically mentally ill. Approximately two hundred key individuals from across the state of Texas came to listen and respond to nationally and internationally recognized experts on this topic of growing importance.

Prior to the conference, participants were sent a number of published papers thought to be most up to date and germane to the topic at hand. A second set of papers, especially commissioned for the seminar, was also circulated and will ultimately be compiled into the proceedings volume for the seminar. While each of those commissioned papers held special significance and value for the topic of community response to the mentally ill in general or in the state of Texas specifically, one particular paper seemed to relay the background of our current state of mental health law in a way that both laypersons and professionals found extremely useful. Written while she was a staff attorney at the Mental Health Law Project in Washington, D.C. from 1984 to 1988, Arlene Kanter's overview provides a rich and fascinating context for the understanding of the contemporary mental health law arena.

Ms. Kanter is presently professor at Syracuse University School of Law and Director of the Housing and Finance Program, a program designed to meet the housing needs of homeless persons. She earned the J.D. from New York University School of Law and the Ll.M. from Georgetown University Law Center. Currently she is writing a book tentatively titled, "New Neighbors: Expanding Housing Opportunities for People with Mental Disabilities" and continues to serve as a consultant to the Mental Health Law Project.

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CURRENT ISSUES IN MENTAL HEALTH LAW

By Arlene S. Kanter, J.D., Ll.M.

Introduction

Mental health law has come of age. In the past two decades the field of law concerned with the rights of people with mental disabilities has grown dramatically. The federal and state courts, the Congress, and state legislatures have discussed and in some cases created new rights and obligations for people who are labeled mentally ill.

Much of the discussion has focused on the debate between psychiatrists and advocates about compulsory treatment. Psychiatrists charge that protecting people from compulsory treatment leaves them to "die"[1] or "rot"[2] with their rights on. The other side is often equally accusatory, referring to patients as "prisoners of psychiatry."[3]

But while this debate continues, the challenge of providing much-needed services to people with mental illness—voluntary or not—remains largely unmet. The number of homeless people in need of housing, social support, and treatment vividly illustrates the need for advocacy. Some have called for return of the "asylum"—to rehospitalize people who are unable to make it on their own. Yet such proposals are simplistic at best. As John Talbott has written, the choice between rehospitalization and homelessness "is like choosing death by strangulation or death by drowning."[4]

Developing needed services in the community has been difficult. Reliance on the courts and legislatures for adequate systems of mental health care has met with mixed success. Such systems are expensive, and legislatures are generally reluctant to mandate new spending. Courts vary in their approach. Some judges will aggressively protect individual rights and entitlements, ordering the

provision of services at any cost. Other courts are either baffled by the legal issues in mental health care or unwilling to order expenditure of state funds. Further, even if courts recognize violation of a legal right, few involve themselves in implementation—a process that is tedious at best and fraught with political, administrative, and legal pitfalls.

Yet despite these apparent obstacles, much has been accomplished in recent years. On the federal level, courts and Congress have struggled with difficult questions around the rights of people with mental disabilities. Such struggles have often resulted in the establishment of new legal rights or the expenditure of substantial resources. On the state level, courts and legislatures have considered such difficult issues as the proper standard for commitment and the practicality of outpatient commitment, referring to an individual's court-ordered treatment in the community.

This paper will explore the developing law with respect to mentally ill individuals' rights to services and treatment, both in and outside of hospital settings.

The Right to Treatment in the Hospital and in the Community

Any discussion of developments in mental health law must begin with a look at the wave of lawsuits brought against mental institutions in the 1970s. Landmark lawsuits, relying on novel constitutional theories, established the rights of people with mental illness as well as developmental disability to treatment and protection from harm,[5] to procedural and substantive protections in the civil commitment process,[6] to safeguards against intrusive and hazardous procedures such as sterilization or forced medication,[7] and to appropriate community services.[8] The legacy of these cases is a growing body of law governing institutional treatment, which has spawned many class actions and individual lawsuits.

The first case addressing the right to treatment was *Rouse v. Cameron*,[9] in 1966. Rouse was committed to Saint Elizabeths Hospital in 1962 after being found not guilty by reason of insanity for a misdemeanor punishable by a one-year maximum sentence. After three years of hospitalization, Rouse petitioned for release on the ground that he had received no psychiatric treatment. The court granted his petition, holding that the "[p]urpose of involuntary hospitalization is treatment, not punishment....Absent treatment, the hospital is transform[ed]...into a penitentiary where one could be held indefinitely for no convicted offense."[10] While the decision was hailed as a victory by those who viewed it as a step forward in reforming the deplorable state hospital where people were confined, then forgotten, it was not until *Wyatt v. Stickney*[11] that the right to treatment emerged as a fundamental legal doctrine.

In *Wyatt v. Stickney*, a United States district court in Alabama made history by ruling that mentally handicapped persons involuntarily confined to a state institution have a constitutional right to treatment. The case began as an effort to stop the state from firing hospital employees because of budget cuts. After studying the record and touring the hospital, Judge Frank M. Johnson, Jr. declared in 1971 that the dreadful conditions there violated civilly committed patients' constitutional right to treatment. He wrote that "involuntarily committed patients unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or improve his or her mental condition."[12] The court went on to state that "to deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the fundamentals of due process."[13]

Accordingly, one year later, a detailed consent decree was adopted, requiring compliance with specific standards on such matters as floor space, toilet doors, and other living arrangements. The decree also imposed patient-staff ratios, required detailed individual treatment plans within 48 hours of admission, prohibited excessive medication and the use of medication as a punishment or for staff convenience or as a substitute for programs, required that work done by patients must be voluntary and compensated at minimum wages, restricted physical restraint and isolation, and guaranteed to patients their right to privacy, mail, phone, and visitors.

The legal theory in *Wyatt* and its progeny is straightforward: When the state deprives an individual of liberty in order to provide treatment, it has an obligation to provide that treatment. Nonetheless, *Wyatt* was criticized sharply as improperly encroaching upon the psychiatrist's purview—criticism that was repeated following the Supreme Court's historic decision in establishing the right to liberty, in *O'Connor v. Donaldson.*[14]

Kenneth Donaldson had been civilly committed and confined for 14 years when he sued state hospital psychiatrists for damages, alleging that members of the hospital staff had intentionally and maliciously deprived him of his constitutional right to liberty. On June 26, 1975, the United States Supreme Court unanimously held that patients "who are not dangerous to themselves or others, are receiving only custodial care and are capable of surviving safely in freedom or with the help of family or friends" could not be institutionalized against their will.[15]

The next step after *Wyatt* and *Donaldson* in the Supreme Court came in 1982 with the Court's decision in *Youngberg v. Romeo,* 457 U.S. 307 (1982). In *Youngberg,* the Court was, for the first time, presented with the task of outlining the scope of the rights of people with mental retardation under the fourteenth amendment to the United States Constitution. In *Youngberg,* an institutionalized person with mental retardation, through his mother, sued the state claiming his constitutional rights had been violated by the state facility's failure to provide him with adequate treatment and by the facility's use of inappropriate treatment, including mechanical restraints. The Court, in an unanimous decision, held that the substantive rights provided by the United States Constitution define only the minimum. Although the resident had a constitutional right to training in basic self-care skills to help minimize his aggressive outbursts consistant with his liberty interest in avoiding frequent restraints, as well as certain limited rights to adequate food, shelter, clothing, medical care, safety and freedom of movement, none of these rights was "absolute." According to the Court, these rights are subject to implementation consistent with "professional judgment." In short, the Court failed to recognize a *per se* right of people with mental retardation to treatment or to be treated in the least restrictive environment. The issue is still unresolved, however, for people with mental illness.

In two other cases, courts have established a right to treatment in the least restrictive setting for residents of state mental hospitals. In *Brewster v. Dukakis*[16] and *Dixon v. Weinberger*,[17] patients confined to state hospitals brought class-action lawsuits to establish that they had a right to placement in less restrictive settings outside the hospital—in particular, placements consistent with their treatment needs. Such a right presumes the state's continuing responsibility to provide basic care, shelter, and other necessities while retaining the minimum amount of control over the individual. Conflict arises, however, when the state is ordered to develop services in the community in order to allow the individual to leave the institution.

Brewster was filed in 1976 on behalf of institutionalized and noninstitutionalized people in the western part of Massachusetts. The case was brought to compel the state to implement a 1966 state law empowering the Department of Mental Health to create a comprehensive system of community programs instead of enhancing services in the large state hospitals. *Brewster* was settled in 1978, and its effect has vastly improved community-based services in western Massachusetts.[18]

Filed in 1974, *Dixon v. Weinberger* sought to establish that under the United States Constitution and District of Columbia statutes, patients at the federally operated St. Elizabeths Hospital in Washington, D.C. had a right to treatment in less restrictive facilities, consistent with individual needs. On December 23, 1975, the federal district court held that the city and federal governments had a joint obligation under D.C. law to provide suitable care and treatment outside the hospital to all patients who did not require hospitalization. The court ordered both defendants to develop a plan for the creation of a continuum of community-based facilities as the basis of a remedial order.[19] After lengthy negotiations, a plan was accepted and approved by the court in April 1980. The plan and accompanying consent order represented a major effort to address the many and difficult problems involved in implementing such a judicial order, including sound planning for the necessary changes, convincing the bureaucracy to accept changes, and designing an effective monitoring system to ensure compliance.

The settlement required the city and federal governments to assess the needs and capabilities of every patient and set standards for mental health care, adequate and appropriate residential ser-

vices, and support services in the community. In sum, the decree, with its accompanying plan and standards, is a model for a comprehensive mental health system. Nevertheless, its goals have not been realized. Even after contempt proceedings, the local government has been slow to dedicate the resources and effect the structural changes necessary to implement the decree.

Cases that have followed *Dixon* and *Brewster* in seeking to establish the right to treatment in the community illustrate the continuing uncertainty about the scope of remedies. Approximately half of the states now have laws that require habilitation, normalization, or the provision of services in the least restrictive setting for people with developmental disabilities or mental retardation. By contrast, fewer than 15 states have statutes requiring or even encouraging services in the least restrictive environment for people with mental illness. And of those, only three create entitlements to deinstitutionalization and community services. Accordingly, many people who could benefit from care in a community setting find such care unavailable.

One reason is money. The vast majority of states' mental health dollars remains tied to hospitals, leaving few community-care options available to discharged patients. Yet the state mental hospitals serve a diminishing proportion of the people who are mentally ill. Almost 70 percent of public mental health dollars ($4.1 billion) was spent on state hospitals in one recent year,[20] although most people who need emergency inpatient care are treated as psychiatric admissions to general hospitals, Veterans Administration facilities, or private hospitals.[21] And those who need non-crisis services are theoretically treated in the community, where they live.[22] But because people with mental illness often have no resources and their caseworkers can seldom find a community agency that will provide them future care, discharge too often means return to the streets.

Access to quality mental health care cannot improve, therefore, unless the resources shift from the state institutions to the community. In Louisiana, for example, 103 state hospital patients were discharged into the community, and six wards were closed. More than one million dollars was saved, and the allocation was permanently transferred to support community programs for the 103 patients and others. Even the closing of state hospitals is now being seriously entertained. In Vermont, a recent study recommended

closing the state's only mental hospital and using the savings to help pay for community programs.[23]

Federal courts have generally been unwilling to reallocate mental health dollars from institutions to the local level in part because of their unwillingness to recognize a constitutional right to mental health treatment in the community.[24] However, a more common and so far more successful strategy for the reallocation of mental health dollars has been state-court litigation.

Lawsuits filed in state courts ask the courts to hold that laws requiring specific services be considered an obligation the state government cannot abandon, even if funds for those services are lacking. State courts have generally seemed hospitable to such suits challenging the failure to implement mandatory community programs. For example, in a recent Arizona case, the plaintiff class, indigent mentally ill residents of Maricopa County, asked the state court to compel the Department of Health Services, Arizona State Hospital, and the County Board of Supervisors to perform duties required by state mental health law, which include creating a unified and cohesive system of community mental health care. Although the defendants claimed inadequate funds, the lower court ordered them to fulfill their mandate.[25] *Arnold v. Sarn* is the first decision by a state court to order the development of a comprehensive system of care for chronically mentally ill people.[26] The case is now on appeal to the state's highest court.[27]

The *Arnold* decision is particularly instructive regarding the factors necessary to create such a system. Using as one model the consent decree in *Dixon*, the court ordered the following services as necessary for the operation of an effective system: case management, residential services, day treatment, outreach, medication, outpatient counseling, crisis stabilization, mobile crisis services, socialization, recreation, work adjustment, and transportation. In fact, the court specifically recognized that deinstitutionalized individuals are often at risk of rehospitalization because the residual impairments of their illness interfere with successful adjustment to community life unless they have adequate community mental health services. Accordingly, the court further ordered the Arizona State Hospital to ensure that discharged patients have a place to live as well as an adequate program for necessary treatment.

In addition to the *Arnold* case, *Klosterman v. Cuomo* is a case that, if successful, will result in sevices for mentally ill people who

are homeless.[28] Nine patients discharged from New York State psychiatric facilities into shelters or onto the streets claim violations of their federal and state constitutional and statutory rights to treatment and housing. The state court held that the plaintiffs had no constitutional right to treatment because they were no longer patients of state mental hospitals. The constitutional right to treatment in the least restrictive environment, the court said, applies only when an individual is under restraint or otherwise confined. The defendants also sought dismissal of the suit, but the court held that the plaintiffs could challenge both the state's failure to prepare written service plans for each discharged patient and its differential treatment of current and former patients. According to the court, if the state provides community care to patients discharged from psychiatric facilities but not to severely mentally ill *former* patients, then the plantiffs had a claim under Section 504 of the Rehabilitation Act, which prohibits discrimination on the basis of disability by any program that receives federal funding.

Yet advocates cannot expect that by obtaining a court order they can ensure an adequately funded system of community-based care. In *Mental Health Association v. Deukmejian*,[29] a California court denied relief to two plaintiffs who sought release from a state mental hospital alleging a constitutional right to treatment in the community under the California constitution and state law. Although California law creates a legislative preference for mental health treatment in the least restrictive setting, the California Superior Court held that the statute did not create an absolute right to such treatment. Despite extensive evidence of the deficiencies of the hospital-based system, the court refused to determine how the mental health system should be constructed and funded. It held that states should have considerable latitude in deciding how mental health services should be provided and whether these services should be provided at all. Indeed, it is possible that state courts will not require defendants to do more than actively seek funding from the legislature.

Housing as the Critical Need

In addition to mental health services, many mentally ill people are in desperate need of housing. Without adequate housing or a permanent address, many could not even take advantage of services offered. Yet the combined effects of stigma and economic restrictions have prevented the development of housing options, from group homes to supported independent living units for people with a mental disability.

In addition to actions seeking to compel local and state governments to finance community care, litigation has been brought to keep barriers unrelated to funding from inhibiting the development of community services. These cases generally involve challenges to zoning laws and restrictive covenants.

Literally hundreds of cases in state courts have considered whether a zoning permit was properly withheld from a provider seeking to open a group home or whether a restrictive covenant limiting the use of land to single families could lawfully exclude group homes for people with mental disabilities.[30] In the past couple of years, however, strategies to expand housing for people with mental disabilities have moved beyond traditional zoning battles.

In 1984 the Supreme Court decided *Cleburne v. Cleburne Living Center*,[31] rejecting a city's denial of a permit to open a group home for 13 mentally retarded adults. In a 6-3 decision, the Court upheld the right of a group home to open, concluding that the city's ostensible justifications for denying the special-use permit were either impermissable or unworthy of belief.[32]

Since *Cleburne*, additional cases have rejected efforts to restrict development of housing for people with mental disabilities. A federal court in Florida declared unconstitutional several provisions of a Miami Beach ordinance regulating "adult congregate living facilities." The operators of an adult congregate living facility were denied a special-use permit because the proposed facilities exceeded four stories and were located on streets prohibited by the ordinance. The operators sued, and the court held that, under *Cleburne*, the city's zoning ordinance was unconstitutional because, for no rational reason, it treated residences for disabled people differently from those for other groups.[33]

A similar suit was recently settled in the United Sates District Court in Ashland, Kentucky. In this case, the city responded to a

provider's application to open a group home by rezoning the street on which the home was to open so as to prohibit multi-family uses. When the provider then tried to build and operate an apartment complex for mentally ill and nonmentally ill people, the city rezoned the entire city to prohibit the proposed building. After a suit was brought by the prospective residents and the provider, claiming that the city's actions constituted blatant discrimination against people with mental illness, the city agreed to rescind its changes to the zoning laws and to grant the necessary permits.[34]

Imposing Treatment

Relaxing Civil Commitment Laws

Financing an adequate mental health system and developing housing for people with mental illness are difficult tasks which can take a long time. Some commentators and psychiatrists are calling for quicker "solutions," by changing state civil commitment laws ostensibly to ease the burdens on the community systems.[35] Currently, most states allow involuntary commitment only to individuals who are considered dangerous to themselves or others. In practice, this standard requires that the grounds for commitment be established by objectively verifiable criteria. Some critics of deinstitutionalization would like to see these standards relaxed so that people could be moved "off the streets...and back in facilities designed for people in their condition."[36]

The American Psychiatric Association, in its comprehensive report on the homeless mentally ill, has hailed such attempts to allow homeless people to be committed more easily, under a standard that would permit the commitment of anyone who is "likely to suffer substantial mental or physical deterioration."[37] This alternate standard focuses on whether the person is capable of tending to his or her own physical needs rather than on imminent or

potential dangerousness. It also places decisions regarding commitment in the hands of the medical profession rather than those of the legal community.

This movement toward "reinstitutionalization" is seen by some as responsive to the needs of families who have had to stand by helplessly and watch a loved one slowly degenerate into a seriously disabled person, without being able to provide treatment because the individual refuses.[38] By requiring a court to order involuntary commitment when it concludes that the person "lacks the capacity to make an informed decision concerning treatment," the APA model law permits treatment of involuntary patients without their consent. The drafters of this proposal defend this provision by stating the patients have the right to treatment that is "the most appropriate and therapeutic available." To some, returning people to mental hospitals is "a simple solution to the problems of deinstitutionalization such as homelessness."[39]

Yet the movement to broaden the grounds for involuntary commitment does not respond adequately to the real needs of people who are homeless for decent housing, rehabilitation, and other services. In fact, it may have serious implications for both homeless and nonhomeless people.[40]

The argument for changing commitment is also inconsistent with current trends in mental health care. While it is true that since 1955 the number of residents of state mental hospitals on any given day has dropped from 559,000 to 120,000,[41] these hospitals are not empty. Many mental hospitals have become, instead, short-term, acute-care facilities.[42] In fact, inpatient psychiatric admissions to both state mental hospitals and psychiatric wards of general hospitals have risen to approximately one million a year.[43]

In addition, there is little evidence to suggest that the current civil commitment standards actually prevent people from receiving treatment in mental hospitals. Other factors, such as medical decisions not to hospitalize and the lack of available beds, may play a larger role.[44]

Finally, someone who is committed (regardless of whether existing or proposed standards are applied) will eventually be discharged, often within 20 days.[45] Most states resist increasing their inpatient population, in part because the cost of inpatient care is high and because long-term inpatient care is simply not clinically indicated

in most cases.[46] Committing more people, then, may simply strain hospital resources without securing care for people who may be sick. Indeed, current standards requiring dangerousness for committment cannot adequately determine who does or does not need treatment. There is therefore no guarantee that less stringent standards will not suffer from the same inexactitude.

Outpatient Commitment

Some states are also considering enactment of so-called "outpatient commitment" for people who do not require hospitalization. Outpatient commitment, as currently used, refers to the procedure by which an individual is ordered by a court to receive treatment in the community although he or she does not meet the state's standard for civil commitment.[47] This procedure has recently been enacted in several states, including North Carolina, Hawaii, Georgia and, in slightly different form, in Tennessee.[48]

Outpatient commitment proposals may be well intentioned, seen as a way to help someone obtain treatment and avoid institutionalization. Most such laws have been put forth by those concerned about "revolving door" patients—people admitted to a mental hospital, stabilized and then released, often to shelters or the streets, only to be readmitted again and again. Yet outpatient commitment laws, like the proposals calling for relaxation of commitment laws, will simply not solve the problems they attempt to address.

First, outpatient commitment laws have been proposed as a way to reduce the money spent by states to maintain large state hospitals, based on the assumption that community treatment is less costly than hospital-based care. Such an assumption is correct, but not if the community treatment is mandated indefinitely. As one doctor in North Carolina has stated, a mentally ill person subject to an outpatient commitment order "will stay with us forever," requiring the state to pay for continuous treatment.[49] Accordingly, the state will be forced to pay not only the cost of care for people who are hospitalized under existing commitment laws, but also for those who are required to receive outpatient services on a daily and indefinite basis.

Some states are charging the patients for care. Yet the fundamental problem associated with deinstitutionalization has been the state's failure to provide and adequately fund mental health services in the community. Shifting the fiscal burden to the patient, especially the indigent patient, will not alleviate this problem.

In addition to costing the state money, outpatient commitment may create new problems for a person with a mental illness.[50] First, it is unclear how a court may order a person to comply with outpatient treatment in a state that recognizes the right of a competent mentally ill person to refuse treatment, which many states now do. The "right to refuse" doctrine is based on the traditional theories of the right to privacy and of informed consent, which provide that a person may be treated without consent and against his or her will only if the person is shown to be incompetent—i.e. incapable of making an informed treatment decision. And if a person is found incompetent, a guardian must be appointed to make decisions on his or her behalf. In the context of outpatient commitment, this creates a paradox: A judge can order a person to do something that he or she has a legal right to refuse to do.

Further, it is well established that the greater the infringement of liberty represented by the state action, the more procedural protections must be afforded an individual before he or she may be subjected to the state action. Such protections include the right to notice of the state's proposed action, the right to an attorney, the right to a hearing before a judge within a certain number of days, and the right to cross-examine witnesses. States vary in the protections they provide. But it is clear that someone who is subject to an outpatient commitment order suffers a significant deprivation of liberty and should therefore be guaranteed at least the procedural protections accorded individuals in proceedings for civil commitment as an inpatient.

Finally, it is not evident exactly what type of penalty, if any, will be imposed if a person fails to comply with the terms of an outpatient commitment order. Will the person be sentenced to jail for contempt of court? Or sent to the state mental hospital? Some states have dealt with this issue by choosing *not* to deal with it, including no enforcement mechanism in their state outpatient commitment statutes. Others, such as Tennessee, provide that person can be institutionalized for failing to comply with an outpatient treatment plan, but only after a court hearing.

The United States Supreme Court has recognized that "[a]mong the historic liberties...[is] a right to be free from...unjustified intrusions on personal security."[51] The Supreme Court has also stated that "[n]o right is held more sacred, or is more carefully guarded than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear or unquestionable authority of law."[52]

On the other hand, the individual's liberty interests in being free to decide to seek or refuse medical care or shelter must be balanced against the countervailing interest of the state in the treatment and care of people who are incompetent, under its *parens patriae* or parental power, and in using its police power to protect the public health and safety.

Historically, the state's *parens patriae* power authorizes the state to act on behalf of minors and people who are incompetent to make their own decisions concerning personal safety and welfare.[53] Thus the state may legally exercise its power to assist incompetent people.

The state also has a right to protect the health and safety of its citizens. The courts have strictly limited this police power, however, to the extent that it is exercised at the expense of an individual's liberty interests.[54] In balancing the interests of the state and the individual, courts have weighed such factors as the level of intrusion of the person's liberty, the degree of societal harm, and the level of certainty that state intervention will prevent such harm. For example, courts have upheld requirements of vaccination to prevent epidemics,[55] laws requiring that helmets be worn by motorcyclists,[56] and mandatory fluoridation of the water supply.[57] In other words, the state's interest in saving the lives of its citizens may justify the intrusion of coercive treatment or confinement in a shelter.

However, where the harm to the individual (such as the harm to a homeless person remaining on the street) is more speculative and less imminent, the state would have greater difficulty justifying the level of intrusion involved in involuntary treatment or confinement. As mentioned above, the Supreme Court held in the *Donaldson* case that without additional justification the state has no right

to confine a person who is not dangerous to others and who is capable of surviving safely in freedom by him- or herself or with the help of willing and responsible family members or friends."[58]

In New York City the Mayor has put these principles to the test. He has ordered the police to transport homeless people to emergency rooms of a municipal hospital for psychiatric or medical evaluation when the temperature drops below freezing.[59] The policy raises many questions. Although designed to protect a homeless person from freezing to death, it may cause more problems than it solves.

Outreach to people who are homeless and mentally ill is extremely difficult. They often hide, purposely not to be found. However, experience has shown that homeless people, including homeless people who are mentally ill, generally manage to satisfy their essential needs. They become familiar with a network of "services" and develop a pattern of supportive living, finding food at soup kitchens or from mobile teams and passers-by, and shelter in doorways, on heat grates, in subways and bus terminals.[60]

On October 28, 1987, Mayor Koch's policy was challenged. New York City psychiatrists took Joyce Brown (aka Billie Boggs) from the sidewalk where she had lived for nearly a year and a half, brought her to Bellevue Hospital, injected medication and confined her in a locked ward. Ms. Brown had been examined at psychiatric emergency rooms at least five times that year and found not to require involuntary hospitalization. The city's own statistics revealed that nearly half of the 215 people brought to emergency rooms from the street by city psychiatrist teams in 1988 were found not to require hospitalizaton.

Subsequently Ms. Boggs challenged the Mayor's policy and a lower court agreed. However, the lower court's decision was reversed by an intermediate state appeals court, which held that Ms. Boggs was mentally ill and needed treatment to prevent serious harm to her well-being.[61] It is well established in New York that "a person may be involuntarily confined for care and treatment, where his or her mental illness manifests itself in neglect or refusal to care for themselves to such an extent that there is presented serious harm to their own well-being." The appeals court found significant evidence that Ms. Boggs was in need of such treatment. Consequently she was involuntarily committed. Once back in the hospi-

tal, Billie Boggs refused medication. She went back to court and the court agreed that under New York law she could not be forcibly medicated in nonemergency situations. The hospital then released her because they could not treat her with medication against her will.

Refusing Medication

The right to refuse treatment, particularly medication, is unquestionably one of the most controversial subjects in mental health law today. Voluntarily admitted patients have generally enjoyed such a right—at least in theory. Involuntarily committed patients' right to refuse treatment, particularly antipsychotic medication, has been quite another matter. Nonetheless, several courts have affirmed that even involuntarily committed patients have a constitutional right to refuse treatment in certain circumstances.

To call the debate one about the right to refuse medication is somewhat misleading, however. Until recently, there was no dispute that patients had a right to refuse treatment, including medication, as a corollary of the legal requirement of informed consent prior to treatment. The administration of treatment (even beneficial treatment) without consent is prohibited as unlawful assault and battery and punishable by criminal as well as civil penalties. The real question then is what is required to override a patient's refusal.

Most concede that the right to refuse medication can be overcome in emergencies involving imminent danger to physical health of the individual or others. Recent court decisions all recognize that forced medication must be permitted in certain emergencies, at least in institutions. But most courts have required that the decision to treat must be made by a qualified physician, less restrictive alternatives to medication must be demonstrably insufficient, and the primary purpose of the medication must be to mitigate a physical emergency, not merely to treat.[62] A further limitation is that the emergency must occur in an institution. While the courts have not yet ruled precisely whether someone living in the community may be forcibly medicated, language in some cases seems to indicate that they may not. For example, the Eighth Circuit Court of Appeals recently noted that "an individual

who is not in full-time custody, care and treatment at a hospital cannot be forcibly medicated."[63] And in *Rennie v. Klein*, the Court of Appeals for the Third Circuit stated: "An individual who has not been committed to a mental institution has a right to refuse medication sought to be administered against his will."[64]

The question then becomes under what circumstances may the patient's refusal be overridden in a nonemergency situation? Some federal courts have held, and the American Psychiatric Association has argued, that all that is required is exercise of a psychiatrist's professional judgment to override any patient's refusal.[65] Most courts, however, recognize that a threshold issue is the competence of the individual refusing medication.

Competence is a different legal concept from mental illness or commitability; it means having the capacity to make decisions about health treatment. Most courts hold that a person who is competent has a right to make such decisions. Another key issue is, therefore, who decides whether or not a patient is competent. Advocates argue for judicial decision; states argue that doctors can make this decision, with or without the aid of "independent" hospital-based review boards. Some courts have held that if a patient is incompetent, a hospital can go ahead and forcibly medicate;[66] others require that hospitals still go to court and that courts make a "substituted judgment" decision or a decision in the patient's best interests.[67]

The lower court in *Rogers v. Commissioner of Mental Health*, one of the first courts to consider this issue, held that incompetent patients, like others, cannot be medicated without consent except in emergencies.[68] It further held that only a patient's legal guardian can supply the necessary consent. The appellate court in *Rogers* and other courts have deferred more to attending clinicians. For example, in *Rennie v. Klein*, the court would permit teams of clinicians, acting according to specified procedures, to override even guardians' decisions or to make their own decisions when it is difficult to obtain the guardian's consent.[69] The *Rennie* court carved out another exception to the general rule prohibiting forced medication. It held that a committed patient may be medicated against his or her will if "without [medication] the patient is incapable of participating in any treatment plan that will give him a realistic opportunity to improve his condition, or if it will shorten the required commitment time."[70]

Most courts have rejected such an exception. They reason that, except in an emergency, the sole justification for medication is to help the patient and, absent a finding of incompetence, all persons, including those involuntarily confined, have a right to decide whether and how they wish to be treated.[71]

A couple of recent cases illustrate these points. In cases decided less than one month apart, two federal appeals courts reached dramatically different conclusions. In *United States v. Charters*, the Fourth Circuit Court of Appeals upheld the right of a person found incompetent to stand trial to refuse psychotropic medication.[72] The court declared that refusal can only be overridden in an emergency or when the patient has been found by a court to be incompetent to make decisions about medical care. The appeals court also reviewed the standard to be followed in the case of a person who is incompetent to make decisions about his or her medical care. It rejected a "professional-judgment standard," adopting instead a "substituted judgment standard." This standard provides that a determination must be made based on what the patient would have chosen if he or she were competent and, if that is not possible, what decision would be in his or her best interest. The question remains, however, whether this case applies to civilly committed individuals and whether the outcome would be different if "without medication a patient will suffer a severe, immediate and irreversible deterioration."

The Eighth Circuit Court of Appeals, in *Dautremont v. Broadlawns Hospital*, held that decisions to forcibly medicate a civilly committed patient must be the result of the exercise of professional judgment.[73] This court reasoned that although the patient's "liberty from bodily restraint, and therefore, arguably, mental restraint, survives involuntary commitment," the liberty interest was outweighed by the government's legitimate interests. Here, according to the court, the government's interests included returning the patient's behavior "to that which is acceptable to society and by the professionals' reasonable judgment here that the objective can best be accomplished by the administration of certain types and levels of psychotherapeutic drugs."[74]

The reasons to refuse medication considered most persuasive to courts continue to be religion and concerns about contracting tardive dyskinesia. Courts take both very seriously. In several

jurisdictions a person with religious objections is entitled to a judicial hearing before being forcibly medicated, while the rights of people with nonreligious objections are unresolved.[75]

In Indiana, for example, the supreme court, emphasizing a person's liberty interest in being free from intrusions into the body and mind, as well as the dangers associated with tardive dyskinesia, recently established standards to decide when a patient may refuse medication under an Indiana statute permitting a person to petition a court asserting a right to refuse medication.[76] In *In Re M.P.*, the court held that in order to override a patient's statutory right to refuse treatment, the state must demonstrate by clear and convincing evidence (1) that a current and individual medical assessment of the patient's condition has been made; (2) that it resulted in the honest judgment of the psychiatrist that medication would be of substantial benefit in treating the patient's condition, and not just a means of controlling the individual's behavior; and (3) that the probable benefits from the poposed treatment outweigh the risk of harm to, and personal concerns of, the patient. This court is the first to reject the possibility of dangerousness as a justification for medicating a person without obtaining prior authorization from a court. The Indiana court also emphasized that forcible medication could not be ordered unless the court found it to be the least restrictive alternative, and that all forcible medication orders must be periodically reviewed and medication stopped if a patient did not substantially benefit from the treatment.[77]

Conclusion

The development of mental health law has been rapid. Courts have recognized new rights and, arguably, taken away others. For institutionalized individuals, the exact parameters of the right to treatment and community placement and to refuse medication have begun to be clarified. Yet lack of resources as well as prejudice continues to prevent people with mental illness from being truly integrated into our society. In short, the issue of the rights and services to which people are entitled is likely to continue as a major battleground in the years ahead.

Yet, as the history of the development of mental health law shows, courts have the potential to become significant players in the effort to develop community-care systems which provide decent conditions for people with mental illness. But it remains for ex-patients, consumers, family members, health care professionals, lawyers and other advocates to work together to fulfill that potential. Surely one of the greatest challenges facing us all is to identify and implement strategies that will expand the availability of effective and quality community services and decent and low-cost housing. Failure to do so may result in either a return to the days of large custodial institutions or the reality of people left to live and die on the streets of our nation's cities.

ENDNOTES

1. Treffert, D., "Dying with Their Rights On" (letter). 130 *American Journal of Psychiatry*, 1041 (1973).

2. Appelbaum, P. Gutheilil, T. "Rotting with their Rights on": Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients, 7 *Bulletin American Academy of Psychiatry and Law*, 308–317 (1979).

3. Ennis, P. *Prisoners of Psychiatry* (1972). New York: Harcourt Brace Jovanovich.

4. Cordes, C. (April 1985). A Step back. *APA Monitor*, p. 4.

5. *E.g., Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 and 387 (M.D. Ala. 1972), *aff'd sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974); *New York State Association for Retarded Children v. Carey*, 393 F. Supp. 715 (E.D.N.Y. 1975).

6. *E.g., Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wisc. 1972), *vacated*, 414 U.S. 473 (1974), *modified*, 379 F. Supp. 1376 (E.D. Wisc. 1974), *remanded*, 4211 U.S. 957 (1975), *prior judg. reinstated*, 413 F. Supp. 1318 (E.D. Wisc. 1976). *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

7. *E.g., Wyatt v. Aderholt*, 368 F. Supp. 1382 (M.D. Ala. 1973) (state statute authorizing involuntary sterilization of mentally disabled women held unconstitutional). *See also* 42 C.F.R. §§50.201-50.210, which prohibit the use of federal funds for involuntary sterilization of mentally handicapped children or adults. *See also Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), and *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978), *aff'd*, 720 F.2d 266 (3d Cir. 1983) (recognizing right to refuse medication in non-emergency situations).

8. *E.g., Dixon V. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975).

9. *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966).

10. *Rouse v. Cameron, supra*, 373 F.2d at 452-53.

11. *Wyatt v. Stickney, supra*, 373 F. Supp. 781 (M.D. Ala. 1971).

12. *Wyatt v. Stickney, supra*, 325 F. Supp. at 784-785.

13. *Id.*

14. *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

15. *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

16. *Brewster v. Dukakis*, No. 7-76-4423-F (D. Mass. 1978), 675 F.2d 1 (1st Cir. 1982).

17. *Dixon v. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975).

18. After the *Brewster* decree was finalized, the state legislature refused to appropriate sufficient funds to carry out the decree and the court of appeals refused to compel the

legislature to do so. *Brewster v. Dukakis*, 675 F.2d 1 (1st Cir. 1982). The *Brewster* decree then became the subject of political negotiation and the result is one of the nation's most successful community mental health programs.

19. At the time the lawsuit was filed, St. Elizabeths Hospital was owned by the federal government on land leased to it by the District. In November 1984, Congress passed legislation providing that by 1991 the hospital will be the sole responsibility of the District of Columbia government. Pub. L. 98-621, 98 Stat. 3369-3382.

20. In fact, funds allocated to inpatient care actually totaled more than $4.1 billion considering that funds for private and county hospitals were not included in the 70 percent figure. *See* Rubenstein, L., "Access to Treatment and Rehabilitation for Severely Mentally Ill Poor People," 20 *Clearinghouse Review*, 382-85 (Summer 1986).

21. *Id.*

22. The National Institute of Mental Health also estimates that of the 2.4 million people labeled chronically mentally ill, 1.5 million now live in the community. And of those, 110,000 people are in short-term treatment in hospitals, 290,000 live in halfway houses or group homes and 1.1 million live in private homes by themselves or with their families. Morgenthau, T., "Abandoned," *Newsweek* (Jan. 6, 1986).

23. Carling, P., *et al.*, *A Feasibility Study to Examine the Development of A Regional Community Mental Health System As An Alternative to Vermont State Hospital* (1985).

24. Two courts of appeals have held that institutionalized people have no constitutional right to placement in the community. *Society for Goodwill to Retarded Children, Inc. v. Cuomo*, 737 F.2d 1239 (2d Cir. 1984), and *Phillips v. Thompson*, 715 F.2d 365 (7th Cir. 1983). A recent Fourth Circuit decision, however, reached a different result. In *Thomas S. V. Morrow*, 781 F.2d 367 (4th Cir. 1986), the Fourth Circuit Court of Appeals upheld the right of a 20-year-old man diagnosed with schizophrenia, mental retardation and incapable of living independently to treatment in a community-based setting. Rejecting an inadequate-resources defense, the court held that money is simply not relevant in determining the scope of an individual's constitutional right.

25. *Arnold v. Sarn*, No. C432355 (Ariz. Superior Ct., Maricopa Cty., June 25, 1985).

26. *See also Goebel v. City & County of Denver*, No. 81MH270 (Probate Ct., City & Cty. of Denver, May 7, 1985) (court held lack of sufficient funds did not excuse defendants of their statutory duties to provide plaintiffs with care and treatment in the community).

27. *Arnold v. Arizona Department of Health Services, et al., appeal pending*, No. CV-87-0454-T (Arizona Sup. Ct).

28. *Klosterman v. Cuomo*, 463 N.E.2d 588 (N.Y. Ct. App. 1984), 481 N.E.2d 580, 126 Misc. 2d 247 (N.Y. Sup. Ct., N.Y. Cty., Oct. 2, 1984). *See also Joanne S. v. Carey*, No. 18493/82 (N.Y. Sup. Ct., filed Aug. 10, 1982), a parallel case filed on behalf of the 140 patients of the Manhattan State Psychiatric Center who claim that they are unlawfully confined because there is no place in the community for them.

29. *Mental Health Association v. Deukmejian*, No. CA 000 540 (Cal Super. Ct., Los Angeles Cty., April 12, 1985).

30. For a compilation of such cases *see* Kanter, A., "Recent Zoning Cases Uphold Establishment of Group Homes for the Mentally Disabled," 18 *Clearinghouse Review* 515-18 (1984).

31. *Cleburne v. Cleburne Living Center*, 53 U.S.L.W. 5022 (U.S. July 1, 1985), 105 S.Ct. 3249 (1985).

32. *Cleburne v. Cleburne Living Center, supra*, 53 U.S.L.W. at 5026.

33. *Burstyn v. City of Miami Beach*, 633 F. Supp. 528 (S.D., Fla. 1987). Similarly, in *Sullivan v. City of Pittsburgh* 811 F.2d 171 (3d Cir. 1987), the city tried to close an alcoholism treatment center by refusing to issue the required conditional-use permits. The city argued that it made the decision on the basis of community opposition to the center. The federal court of appeals upheld the opening of the center, concluding that the opposition was motivated by prejudice against handicapped people and that the city "took its essentially unjustified action in an atmosphere charged with hostility toward a minority group."

34. *Pathways v. Ashland*, No. 87-82 (E.D. Ky. Dec. 17, 1987).

Other cases involving federal constitutional issues are:

J.W. v. City of Tacoma, 720 F.2d 1126 (9th Cir. 1983), in which the Ninth Circuit Court of Appeals held that the local zoning authority failed to pass a stringent test to prohibit mentally ill individuals from living together in a group home. The case involved eight individuals with histories of psychiatric hospitalization.

Lieberman v. Board of Tax Review, No. CV 850076085 (Conn. Super. Ct. May 14, 1987), in which a group of property owners in Greenwich, Connecticut who were unsuccessful in preventing the opening of a group home for mentally ill adults in their neighborhood petitioned the tax review board to lower assessments on their homes. The tax board agreed to lower assessments, based solely on the neighbors' fear that the presence of the home justified the reduction. Connecticut's attorney general, Sen. Lowell P. Weicker, Jr. (as a Greenwich taxpayer) and Mental Health Law Project (on behalf of an association of group home operators) filed suit against the tax review board, charging that its decision was motivated solely by prejudice and fear. The case was settled with the town agreeing not to use the existence of the group home as a factor in calculating the assessments.

People v. 11 Cornwell Company, 695 F.2d 34 (2d Cir. 1982), in which a group of neighbors in a suburb of New York City, upon hearing that a group home was planned, bought the property on which the home was to be located. The state sued the property owners on the grounds that their action violated the civil rights of the propsective residents and the New York human rights law. The Second Circuit Court of Appeals agreed.

35. Currently, about one-third of the states have adopted standards for civil commitment providing that only people who are mentally ill and dangerous may be committed. The remaining states have a less stringent standard, providing commitment of those who are "gravely disabled." For the most up-to-date compilation of state commitment laws, *see* pp. 33-46 in Brakel, S. *et al.*, *The Mentally Disabled and the Law*. Chicago: 1986.

36. Perkins, J., New Institution for the Homeless, *Wall Street Journal*, February 26, 1985.

37. Lamb, H.R. (ed.), *The Homeless Mentally Ill: A Task Force Report of the American Psychiatric Association*. Washington, D.C.: American Psychiatric Association Press (1984).

38. Dunham, A., APA's Model Law: Protecting the Patient's Ultimate Interests, 36 *Hospital and Community Psychiatry* 973, 974 (September 1985).

39. *See* Borus, J., Deinstitutionalization of the Chronically Mentally Ill, 305 *New England Journal of Medicine*, 339 (1981); Feldman, S., Out of the Hospital, Onto the Streets: The Overselling of Benevolence, 13 *Hastings Center Report* 5 (1983).

40. *See* Holden, C. Broader Commitment Law Sought, 230 *Science* 1253 (1985).

41. Goldman, H., et al., "The Multiple Functions of the State Hospital," 140 *American Journal of Psychiatry* 296 (1983).

42. In 1981 more than 370,000 people were admitted to state mental hospitals, the vast majority of whom were released within two months (the acute care patient). United States Department of Health and Human Services, National Institute of Mental Health, *Mental Health United States, 1985*, Tables 2.3 and 2.8.

43. Craig and Laska, Deinstitutionalization and the Survival of the State Hospital, 34 *Hospital and Community Psychiatry* 616 (1983); Weinstein and Cohen, Young Chronic Patients and Changes in State Hospital Populations, 35 *Hospital and Community Psychiatry* 595 (1984).

44. Rubenstein, L., APA's Model Law: Hurting the People It Seeks to Help, 36 *Hospital and Community Psychiatry* 968, 970 (1985).

45. The median length of stay in state and county mental hospitals is 23 days with people diagnosed with schizophrenia remaining the longest (42 days) and alcohol and substance abusers remaining the shortest (12 days). United States Department of Health and Human Services, National Institute of Mental Health, *Mental Health United States, 1985*, Table 2.17.

46. *See, e.g.*, Goldman and Shore, Beyond Deinstitutionalization, 311 *New England Journal of Medicine* 832 (1984).

47. "Outpatient commitment" is not a single procedure but encompasses three very different approaches to compulsory community care. First, it refers to the process by which an individual who no longer satisfies the standard for inpatient commitment may be required to obtain community treatment. This procedure is also known as "conditional release." "Outpatient commitment" may also mean involuntary community treatment imposed as a dispositional alternative by a court in a commitment hearing, requiring the client to receive community treatment as a less restrictive alternative to inpatient hospitalization. And finally, in its most recent form, it authorizes a court to order an individual who does not meet the standards for commitment to receive treatment on an outpatient basis.

48. For an analysis of these laws, *see* Stefan, S., Preventive Commitment: The Concept and Its Pitfalls, 2 *Mental & Physical Disability Law Reporter* 288-302 (July-August 1987). *See also* Owen, J., *Involuntary Outpatient Commitment: An Explanation of the Issues and Its Utilization in Five States*, National Institute of Mental Health (November 1985).

49. Stefan, S., Preventive Commitment: The Concept and Its Pitfalls, 2 *Mental & Physical Disability Law Reporter* 288-302 (July-August 1987).

50. *See* Hiday and Goodman, "The Least Restrictive Alternative to Involuntary Hospitalization, Outpatient Commitment: Its Use and Effectiveness," *Journal of Psychiatry and the Law* 81 (Spring 1982).

51. *Ingraham v. Wright*, 430 U.S. 651, 672-73 (1977).

52. *Union Pacific Railway v. Botsford*, 141 U.S. 250, 251 (1891); *see Faretta v. California*, 422 U.S. 806, 834 (1975); *Roe v. Wade*, 410 U.S. 113 (1973).

53. *See O'Connor v. Donaldson*, 422 U.S. 563, 583 (Burger, C.J. concurring).

54. *See generally*, Tribe, L., *American Constitutional Law* at 896 (1978).

55. *Jackson v. Massachusetts*, 197 U.S. 11 (1905).

56. *State v. Also*, 11 Ariz. App. 227, 230, 463 P.2d 122, 125 (1969).

57. *Schuringe v. City of Chicago*, 198 N.E. 2d 326, 333-34, *cert. denied*, 379 U.S. 964 (1965).

58. *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975); *see also Addington v. Texas*, 441 U.S. 418, 425 (1979).

59. The policy takes effect whenever the Health Department declares a cold weather emergency, which is defined as the time the temperature drops below 32°F, between 4 pm and 8 am. Philadelphia enacted a similar directive the following year. In New York, the patrol officers must make the initial judgment that a person is homeless and incompetent to care for him or herself in cold weather. They must then request that a sergeant from their precinct concur in their evaluation. If so, they are required to transport the homeless person involuntarily to a "Health and Hospital Corporation emergency room for medical and psychiatric evaluation and, if appropriate, admission."

60. Coleman, To Expert Eyes City Streets Are Open Mental Wards, *The New York Times*, Nov. 4, 1986 at B1, col 1; Coleman, For Mentally Ill in the Streets a New Approach Shines, *The New York Times*, Nov. 11, 1986, at C1, col.1; Hevesi, Homeless in the City: A Day on the Streets, *The New York Times*, Nov. 17, 1986 at B1, col. 1; Shifren-Levine, I., et al., Community Support Systems for the Homeless Mentally Ill, *New Directions: The Homeless Mentally Ill* (E. Bassuk, ed.) Boston: 1986; Coleman, Diary of a Homeless Man, *New York Magazine*, Feb. 21, 1983 15 27.

61. *Boggs v. New York City Health and Hospitals Corp.*, 523 N.Y.S. 2d 71 (N.Y. App. Div. 1987).

62. *See Rennie v. Klein*, 653 F.2d 836, 846-48 (3d. Cir. 1981) and *Rogers v. Okin*, 634 F.2d 650, 656 (1st. Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 102 S.Ct. 2442 (1982).

63. *Lappe v. Loeffelholz*, 815 F.2d 1173, 1179 (8th Cir. 1981).

64. *Rennie v. Klein*, 653 F.2d 836, 843 (3d Cir. 1981).

65. *Dautremont v. Broadlawns*, No. 86-1977 (8th Cir. Aug. 20, 1987).

66. *Riese v. St. Mary's*, No. AO3 4048 (Cal. Ct. App. Dec. 16, 1987), *appeal pending*, No. S004002 (Cal. 1988); *In re K.K.B.*, 609 P.2d 748 (Okla. 1980).

67. *Rogers v. Commissioner of Mental Health*, 458 N.E.2d 501 (Mass. 1983) *People v. Medina* 705 P.2d 96 (Colo. 1985).

68. *Rogers v. Commissioner of Mental Health*, 458 N.E.2d 501 (Mass. 1983).

69. *Rennie v. Klein*, 653 F.2d 836 (3d cir. 1981).

70. *Rennie v. Klein, supra*, 653 F.2d at 848.

71. *See, e.g., Davis v. Hubbard*, 506 F.Supp. 915, 931 (N.D. Ohio 1980), and *In re K.K.B.* 609 P.2d 747, 750 (Okla. 1980).

72. *United States v. Charters*, 829 F.2d 479 (4th Cir. 1987), *reh'g granted en banc* May 2, 1988.

73. *Dautremont v. Broadlawns*, No. 86-1977 (8th Cir. Aug. 20, 1987).

74. *Dautremont v. Broadlawns*, No. 86-1977, slip op. at 6 (8th Cir. Aug. 20, 1987).

75. *See e.g. In re Milton*, 505 N.E.2d 255 (Ohio 1987) and *In re Bryant*, No. MH-1428-85 (D.C. Ct. App. March 25, 1988).

76. *In re M.P.*, 510 N.E.2d 645, 647 (Ind. 1987).

77. Other cases involving refusing medication recently decided by the highest courts of their states include: *Henderson v. Yokum*, No. 79-48A (1st Jud. Cir., S.D. Feb. 19, 1987), which upheld the right to refuse treatment reasoning that use of medication involves invasion of physical and mental liberty interests; *Jarvis v. Levine*, No. C2-86-1633 (Minn. Jan. 15, 1988), which requires a judicial determination of incompetence prior to forcible medication; *State ex rel. Jones v. Gerhardstein*, 416 N.W.2d 883 (Wisc. 1987), which held that the provision of judicial review of treatment refusal to precommitment detainees but not to committed patients violated the state constitution's equal protection clause; and in the latest round of *Keyhea v. Rushen*, No. 67432 (Cal. Sup. Ct., Solano Cty. Oct. 31, 1986), the lower court detailed extensive procedural requirements before the state could medicate prisoners against their will.

CURRENT ISSUES IN MENTAL HEALTH LAW

Hogg Foundation for Mental Health